Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:

Sent

Injury One Treatment Center
5445 La Sierra Drive, Ste. 204
Dallas, TX 75231

APR 14 2008

TX DEPARTMENT OF INSURANCE
DIVISION OF WORKERS' COMPENSATION

MFDR Tracking #: M4-05-5030-01

Inj

E

Insu

Respondent Name and Box #:

Zurich American Insurance Co.
Rep. Box #: 19

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCU

Requestor's Position Summary: "...Medical necessity was established at the time preauthorization was obtained. Zurich included a peer review that was performed by Gregg Vagner, MD on 04.19.2004. This review of records was performed on 04/19/04 the patient at that time had already been approved for her second set of ten sessions of CPM. This review was used in violation of the TWCC rules & orders and was used to deny previously authorized care. In summary, it is our position that Zurich Ins. Has established an unfair and unreasonable decision for the denial of payment for the services that were rendered to [injured worker]."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $200.00*
3. CMS 1500s
4. EOBs

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "...This dispute involves DOS 4/6/04 through 4/26/04 (CPT Code 97799 CA). Carrier has reconsidered these DOS and is re-auditing them at this time..."

Principle Documentation:

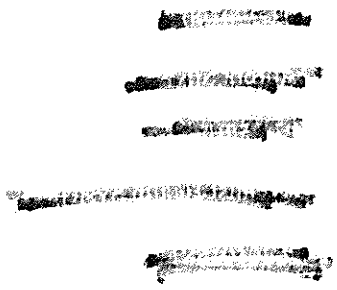
1. Response to DWC 60
2. EOBs showing payment

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
04/06/04	CPT Code 97799-CP-CA	EOB shows payment; no reason code on EOB	1	$0.00
04/19/04 – 04/23/04	CPT Code 97799-CP-CA	A & V, O, No reason code on re-audit EOB	1	$0.00
04/26/04	CPT Code 97799-CP-CA ($125.00 x 8 = $1,000.00 - $800.00 (carrier payment)	V, O, D, M:0B	1, 2	$200.00
Total Due:				$200.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011 (a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective for professional medical services provided on or after August 1, 2003, set out the reimbursement guidelines.



*The Requestors representative, Trisha Noorani, was contacted on April 7, 2007 to inquire if payment had been received as indicated in the insurance carriers' response. All dates of service have been paid correctly except for date of service 04/26/04. The carrier has paid $800.00 of the $1,000.00 billed. Injury One Treatment Center wishes to continue the dispute for the remaining $200.00 of the billed charges for the Chronic Pain Management program.

1. These services were denied by the Respondent with reason code "A – Preauthorization Requested by not Requested"; "V – Unnecessary Treatment (With Peer Review); "O – Denial After Reconsideration; and "D Duplicate Bill." The re-audit EOBs, submitted by the Respondent listed reason code "M:0B" but did not list and explanation of that code.
2. According to Division Rule at 28 Texas Administrative Code Section 134.202(e)(5)(E)(i) and (ii) CARF accredited programs shall add "CA" as a second modifier. Reimbursement shall be $125.00 per hour. The Requestor billed $1,000.00 for 8 units of CPT Code 97799-CP-CA for date of service 04/26/04; the insurance carrier reimbursed the Requestor $800.00; therefore, additional reimbursement is recommended.

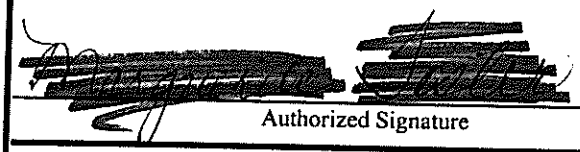
PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1, Section. 134.202
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to additional reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $200.00 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER:



Authorized Signature

Medical Fee Dispute Resolution Officer

April 8, 2008
Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.